

Evidence-Based Practice for Justice Involved Individuals

Expert Panel Meeting

Discussion Paper: Extending ACT to Criminal Justice Settings: Applications, Evidence, and Options

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Introduction

This paper presents an overview of Assertive Community Treatment (ACT) as an evidence-based practice in mental health treatment. We then consider FACTs—ACT for forensic populations—and the ways the ACT model has been extended and adapted to serve mentally ill persons in a variety of criminal justice settings. The available evidence about the cost-effectiveness of FACT will also be highlighted. We then discuss whether FICMs—Intensive Case Management (ICM) for forensic populations—might be a less comprehensive (and possibly less-expensive) alternative to full-fidelity ACT Teams in criminal justice settings. Two key questions arise here: first, can FICMs substitute for FACTs (i.e., produce equivalent results) and, second, is there adequate evidence to support this substitution? We conclude with a series of questions about ACTs, FACTs, and FICMs to stimulate discussion at the GAINS EBP Center Expert Panel Meeting.

Defining ACT

ACT has been defined as a service delivery model in which treatment is provided by a team of professionals with services determined by consumer needs for as long as needed (Phillips et al., 2001). ACT combines treatment, rehabilitation, and support services in a self-contained clinical team made up of a mix of disciplines including psychiatry, nursing, substance use, and vocational rehabilitation (Dixon, 2000; Stein & Santos, 1998). The ACT team operates on a 24-hour 7-day a week basis providing services in the community to offer more effective outreach and to help the consumer generalize the skills to real life settings (Phillips et al., 2001). ACT is intended for consumers who have a severe (a subset of serious with a higher degree of disability) mental illness, are functionally impaired, and at high risk of inpatient hospitalization. Often these consumers have high rates of co-occurring substance related disorders, medical co-morbidities including hepatitis and HIV infections, and social risks including poverty, homelessness, and jail detentions.

Origin and Evolution of ACT

ACT evolved from innovative programs developed in the early 1970s at a state hospital in Madison, Wisconsin that were designed to prevent the revolving door of repeated hospitalizations for persons with severe mental illness (Marx, Test & Stein, 1973; Stein & Santos, 1998). The core idea was to move active treatment away from the hospital into community settings—in effect, to create a hospital without walls in the community—providing the kind of intensive psychopharmacologic treatment that patients would receive in hospital along with a 24/7 crisis response, assertive engagement, and efforts to help consumers improve their community living skills such as finding a place to live, doing laundry, shopping, cooking, eating in restaurants, budgeting, and using transportation.

The ACT adoption rate within the US public mental health system was very gradual throughout the 1980s and well into the 1990s, although it was replicated in other countries including Canada, England, Australia, and Sweden. A major reason for the slow diffusion of ACT in the US was its high per-member cost and consequent intergovernmental politics, especially over which component of government benefited from ACT and which paid for it. As Weisbrod (1983) made clear in the original cost-effectiveness study of ACT, the prime beneficiary in replications of ACT would be the state hospital, saving the costs of caring for people who otherwise would be frequently admitted to acute or reception units that are the high cost centers for most hospitals. The payers, however, would be the federal government (through SSI, Medicaid, housing, and other welfare costs) and the county or local program that would face the direct cost of staffing the ACT Team, but also spill-over costs associated with housing, local welfare, and other public services for consumers who, had they been hospitalized in a state facility rather than assigned to ACT, would be a 100% cost to the state. In effect, Weisbrod's analysis demonstrated that adoption of ACT in other communities would likely result in a cost-shift from the state to the county or local program and federal government.

The adoption rate accelerated when the National Alliance for the Mentally Ill (NAMI) embraced ACT (Allness & Knoedler, 1999), made it a national priority, and created a Technical Assistance Center to coordinate efforts across states and to lobby for Medicaid reimbursement (Torrey et al., 2001). The other contributing factor is the evidence-based practices movement. ACT has become part of most best practice standards including the Schizophrenia Patient Outcomes Research Team recommendations (Lehman et al., 1998) and one of six toolkits being implemented as part of the Dartmouth evidence-based practices project (Mueser, Torrey, Lynde, Singer, & Drake, 2003). The prospect of Medicaid reimbursement altered the reluctance of localities to buy into ACT. Medicaid reimbursements for ACT participants offset the cost barriers faced by the county by shifting a large portion of ACT Team costs from the county to the federal government. Now, over 35 states have implemented ACT to various degrees and a number including New York and Indiana have plans for its rapid deployment on a system-wide basis via Medicaid reimbursement.

In reality, the concept of ACT diffused much more rapidly than its practice. Programs cropped up all over the country claiming to be "just like ACT", but not faithfully replicating the essential structure and staffing. Fidelity ratings to the ACT model became a major focus and standard (Teague, Bond, & Drake, 1998). Fidelity scales have been shown to differentiate true ACT programs from various types of case management and higher fidelity scores have typically been associated with better outcomes (McGrew, Bond, Dietzen, & Salyers, 1994; Teague et al., 1998), but not always (Bond & Salyers, 2004). As newer patient problems such as substance abuse and employment became more prominent, the basic ACT model was enriched with additional staffing and practices to meet these needs (Drake, Mueser, Brunette & McHugo, 2004; McGrew & Bond, 1995). However, no one has conducted a dismantling study to determine which programmatic elements are linked to positive program outcomes. The research to date has shown only that the combination of all the critical elements leads to more positive outcomes (LewinGroup, 2000).

Evidence-Base for ACT

The effectiveness of ACT has been well established with over 55 controlled studies in the US and abroad. In one recent review (Bond, Drake, Mueser, & Latimer, 2001), ACT was found to be most effective in reducing the use and number of days in the hospital, but not consistently effective in reducing symptoms and arrests/jail time or improving social adjustment, substance abuse, and quality of life (also see Burns & Santos, 1995; Dixon, 2000; Marshall & Lockwood, 2004; Ziguras & Stuart, 2000).

Table 1. Significant outcomes for assertive community treatment in 25 randomized controlled trials (adapted from Bond et al., 2001)

| Outcomes | Effectiveness of ACT compared with control conditions (number of trials (%)) ^a | | |
|--------------------------|--|--------------------------|--------------|
| | <u>Better</u> | <u>No Difference</u> | <u>Worse</u> |
| Psychiatric hospital use | 17 (74%) | 6 (26%) | 0 |
| Symptoms | 7 (44%) | 9 (56%) | 0 |
| Quality of life | 7 (58%) | 5 (42%) | 0 |
| Social adjustment | 3 (23%) | 10 (77%) | 0 |
| Substance use | 2 (33%) | 4 (67%) | 0 |
| Arrests/jail time | 2 (20%) | 7 (70%) | 1 (10%) |

When tested against other forms of case management, ACT teams have proven to be more effective only in reducing psychiatric hospitalizations and improving housing stability (Bond et al., 2001; Burns & Santos, 1995; Lewin Group, 2000; Mueser, Bond, Drake, & Resnick, 1998; Ziguras & Stuart, 2000).

“Just the FACTs Ma’am”: Applications to Mentally Ill Offenders and Detainees

There are now about 13 million detentions each year in US jails (J. Karberg, personal communication, September 30, 2004). Based on the best epidemiological estimates (TAPA, 2002) and our on-going research in Washington and Florida (Morrissey et al., 2006a; Morrissey et al., 2006b), we estimate that 500,000 persons with severe mental illness account for about 1 million of these detentions. Jails have now taken on the social custody and time-out role once reserved for state mental hospitals. Indeed, the risk of a person with serious mental illness being detained in jail today is much greater than the corresponding risk of admission to a state mental hospital. The growing recognition of this fact has led a number of programs to shift the focus of ACT from just preventing hospitalization—an increasingly rare event in today’s systems of care—to preventing jail detention and recidivism.

FACT Adaptations

A number of ACT-like programs have grown up in communities around the country that focus on keeping people with severe mental illness out of jails and prisons. The name “forensic ACT Team” or FACT is the emerging designation for these hybrid teams. But little standardization of program practices and staffing currently exists for FACTs. A recent article suggested four core elements that distinguish FACT from ACT, including the goal of preventing arrest and incarceration, requiring that all consumers admitted to the team have criminal justice histories, accepting the majority of referrals from criminal justice agencies, and the development and incorporation of a supervised residential treatment component for high-risk consumers, particularly those with co-occurring substance use disorders (Lamberti, Weisman & Faden, 2004).

Just as in the larger public mental health system, the concept of FACT has disseminated more rapidly than the actual practice of using a high-fidelity ACT team with criminal justice populations. We have identified a few programs that meet this restrictive criterion, but many others use “ACT principles” and FACT designations for programs that are better described as Intensive Case Management (ICM) or, as applied to criminal justice settings, what we will call FICMs.

FICM Adaptations

The ICM model has some distinct differences from ACT and often requires less funding than a full-fidelity ACT team. ICM mirrors ACT with regard to assertive, in-vivo, and time-unlimited services, but it uses case managers with individual caseloads, has no self-contained team, and brokers access to psychiatric treatment rather than providing it directly. Standard case management, on the other hand, is much less intensive due to larger caseloads, often office-based services, and less frequent client contact (Marshall, Gray, Lockwood, & Green, 1998).

When national experts were surveyed about the differences between the ACT and ICM models, the differences were primarily associated with organization and structure (Schaedle, McGrew, Bond, & Epstein, 2002). ICM utilizes individual caseloads with a focus on linking and coordinating services rather than treatment for the consumer, and has a less strict policy for if and when consumers should be transitioned to other services. ACT requires a multidisciplinary team with shared caseloads that meets frequently and uses a comprehensive treatment and rehabilitation model where the psychiatrist and nurse play have a critical role. Additionally, the ACT model spends more time on assertive outreach and has time-unlimited services and a no dropout policy. In developing true costs for FICM, then, one must be careful to include the cost of treatments and other services to which FICM is linked. Since FACT is a more self-contained treatment team, many of these costs are built-in to its cost profile.

FACT and FICM in Criminal Justice Settings

We have located 26 programs in 12 different states that have described their FACT or FICM program as one that serves a forensic population. In Table 2 below, we identify five distinct types of program settings that have developed to serve consumers with serious mental illness who have varying degrees of criminal justice involvement. We have found FACTs and FICMs in all but the one shaded cell. The criminal charges accepted in these programs vary widely, from nonviolent misdemeanors only to a mix of felonies and misdemeanors including violent offenses.

Table 2. Criminal Justice Settings with FACTs or FICMs

| Model | Jails/ Diversion or Re-Entry | MH Court | NGRI | Prison Re-Entry | Multiple Referrals |
|-------|------------------------------------|-------------|------|--------------------|-----------------------|
| FACT | | | | | |
| FICM | | | | | |

Jails refer to either post-booking diversion or re-entry programs following release where consumers are assigned to a FACT Team. Mental Health Court programs provide FACT services to a specialty court for mentally ill detainees; often these programs overlap the jails category. NGRI (not guilty by reason of insanity) programs accept referrals from state hospital forensic psychiatric units for consumers who were acquitted of their crime, treated for a number of months or years, and now released under court supervision. Prison re-entry programs take referrals from the prison system and accept consumers who are released following completion of their sentences or while on probation or parole. Multiple referral programs include a mix of diverted, released, and/or probation/paroled consumers. NGRI is the situation where we have not found FICMs, perhaps owing to a concern for increased intensity of supervision for this population.

Auspice also seems to make a difference here as some of these teams developed from criminal justice initiatives whereas others are mental health system-based. The CJ-sponsored teams are usually distinguished in part by a staffing pattern that includes one or more full-time probation or parole officers. Budgetary issues, collaboration challenges, cost shifts between criminal justice and mental health agencies, and trade-offs between who benefits-who pays all come back into the picture here (Chandler, Peters, Field, & Juliano-Bult, 2004).

The same asymmetry that deterred counties from adopting ACT resurfaces here as well, but the cost shift now juxtaposes county mental health with county or state correctional authorities. Jails and prisons are potentially the prime beneficiaries of FACT in terms of reductions in census, special services, and dedicated staffing. When correctional grant funding for the MIOCRG initiative in California ended in 2004 (see below), most counties did not see a benefit in continuing to fund FACTs or FICMs at the same level through their county mental health budgets. As a result, the programs were

either de-intensified or phased-out completely. Looking to the future, while Medicaid reimbursement might eliminate the financial obstacles faced by county mental health authorities regarding adoption of FACT, it's not clear that the current FACTs would all meet the high-fidelity program standards required for reimbursement.

FACT Evidence-Base

The published evidence on FACT teams is limited to two recent studies (McCoy, Roberts, Hanrahan, Clay, & Luchins, 2004; Weisman, Lamberti, & Price, 2004). Several of the Mentally Ill Offender Crime Reduction Grant (MIOCRG) sites in California started out with the goal of experimentally evaluating FACT Team interventions (Board of Corrections, 2004), but with Board of Corrections (BOC) budget reductions, the interventions turned out to be more like FICMs than true FACTs. The BOC was scheduled to deliver a final report to the California Legislature in December 2004 that might provide more evidence, but the report is likely to be more relevant to FICMs than to FACTs.

In a pre-post study (no control group), consumers who completed one year of Project Link in Rochester, NY (Lamberti et al., 2001) had significant reductions in jail days, arrests, hospital days, and hospitalizations. A preliminary pre-post cost analysis also found that Project Link reduced the average yearly service cost per client (Weisman et al., 2004). In two pre-post studies (no control group) after one year at the Thresholds State County Collaborative Jail Linkage Project in Chicago, consumers had a decrease in days in jail and days in the hospital and reduced jail and hospital costs (McCoy et al., 2004; Thresholds State County Collaborative Jail Linkage Project Chicago, 2001). Neither CJLP nor Project Link has reported on any other mental health or quality of life outcomes.

Evidence-Base for Forensic Intensive Case Management (FICM)

The evidence-base for FICM effectiveness comes from several published studies (Cosden, Ellens, Schnell, Yamini-Diouf, & Wolfe, 2003; Godley et al., 2000; Solomon & Draine, 1995; Wilson, Tien, & Eaves, 1995) and from the nine-site SAMHSA Jail Diversion Demonstration where sites used FICM in a service linkage model (Broner, Lattimore, Cowell, & Schlenger, 2004; Steadman et al., 1999; Steadman & Naples, 2005). There is another SAMHSA jail diversion evaluation now underway as part of a Targeted-Capacity Expansion initiative that involves more than 20 sites that use one or another form of FICM (TAPA Center for Jail Diversion, 2004). Findings will be available in the next year.

The basic evidence here is mirrored in the SAMHSA jail diversion findings (Broner et al., 2004; Steadman & Naples, in press). The study involved a non-random comparison group design that used FICM to divert detainees to community treatment services at diverse sites around the country. Diverted individuals reported more days in the community, more service use, and fewer jail days than did the non-diverted comparison groups, but there were no consistent differences on symptoms or quality of

life. In other words, FICM improved public safety outcomes, but it had little or no effect on public mental health outcomes. (One exception is Godley et al. (2000) who report both symptom improvements and jail time reductions.)

Steadman and Naples (in press) argue that the absence of mental health effects in the SAMHSA jail diversion study was due to the treatment services to which diverted individuals were referred. None of them provided evidence-based treatments such as ACT so the referral was equivalent to assigning people with severe mental illness and co-occurring substance abuse disorders to usual care. And, not surprisingly, usual care results (no difference) were obtained. Although FICM was employed by most sites, it was used on a short-term basis preliminary to transitioning consumers to available community mental health providers.

Two random clinical trials have been reported here as well, one from a California MIOCRG site (Cosden et al., 2003) and the other from Philadelphia (Solomon & Draine, 1995). The Philadelphia study compared FICM with FACT and with usual care services finding no significant differences in social or clinical outcomes after one year of services but did find a higher re-arrest rate for FACT (attributed to having probation officers on the team). The California study compared a combined mental health court and FICM model (that also had probation officers as team members) with usual care; at 12-months, both groups exhibited improvements in life satisfaction, psychological distress, independent functioning, and drug problems. No differences were found in time in jail or number of arrests, but in a finding that mimics the Philadelphia study, consumers in the intervention arm were more likely to be booked and not convicted, and to have been arrested for probation violations, whereas, the usual care group were more likely to be convicted of a new crime.

ACT, FACT, FICM, or Fwhat?—can we advise local authorities about practical options and best practices in criminal justice settings?

To date the research remains unclear on the effectiveness of ACT as an evidence-based treatment for forensic populations. There is a great need for a carefully designed randomized study of FACT to see if it improves public mental health outcomes as well as public safety outcomes. In addition, further research is needed on FICM to determine whether it is less-costly and ‘tolerably’ equivalent outcome-wise to ACT/FACT. Given the uncertainties surrounding the current evidence-base, local mental health and criminal justice authorities are searching for some practical options and best practice recommendations. The Expert Panel can inform this search by discussing answers to the following questions:

- Are adaptations needed in the basic ACT model to create FACT for forensic populations?
- FACT for whom? What clinical and/or criminal characteristics are associated with good/poor outcomes with FACT/FICM?
- What is the role of court/corrections supervision/coercion on FACT engagement/outcomes?

- Can local mental health or correctional authorities be persuaded to pay for FACT if it serves predominantly misdemeanor populations?
- If not, is FICM a viable alternative and is it less costly than FACT?
- Can we identify a set of program standards that combine FACT and FICM in a hybrid best practice model with lower costs than FACT alone?
- How can we pay for this best practice model?
- Is the model sustainable beyond grant or start-up funding?

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